RCJ Journal of the Academy of Public Health

Forced treatment in psychiatry is a crime against humanity

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Published: Jan 30, 2025 + DOI: https://doi.org/10.70542/rcj-japh-art-1reghe8

Article

You may be provoked by the title, but it describes a fact. According to the Rome Statute of the International Criminal Court, Article 7,[1] certain acts committed as part of a widespread or systematic attack directed against any civilian population are considered a crime against humanity.

These acts include murder, imprisonment or other severe deprivation of physical liberty in violation of fundamental rules of international law, torture, rape, persecution against any identifiable group, other inhumane acts of a similar character intentionally causing great suffering, or serious injury to body or to mental or physical health.

Attack directed against any civilian population means a course of conduct involving the multiple commission of such acts pursuant to or in furtherance of a State or organisational policy to commit such attack.

Torture means the intentional infliction of severe pain or suffering, whether physical or mental, upon a person in the custody or under the control of the accused; except that torture shall not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions.

Persecution means the intentional and severe deprivation of fundamental rights contrary to international law by reason of the identity of the group or collectivity.

Crimes against humanity are often committed as part of State policies. This is the case in psychiatry where State policies lead to systematic persecution of patients with severe psychiatric disorders, for example schizophrenia, severe depression or severe bipolar disorder.

This group of patients may be subjected to involuntary commitment to a psychiatric department where they might be restrained and forced to take psychiatric drugs or to receive electroshocks against their will and might be incarcerated for an undefined length of time.

I shall argue from a legal, scientific and ethical standpoint why it is wrong and harmful to subject patients to coercion.

In most countries, there are two justifications for using force. People considered insane, or in a similar condition, can be involuntarily admitted if they present a substantial danger to themselves or others, or if the prospect of cure or substantial improvement of the condition would otherwise be significantly impaired.

The intentions about helping patients that cannot take care of themselves are noble but the science shows that what is obtained is the opposite of what is intended.

Psychiatrists increase the risk of suicide and violence

A 2014 Danish register study of 2,429 suicides showed that the closer the contact with psychiatric staff – which often involves forced treatment – the worse the outcome.[2] Compared to people who had not received any psychiatric

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treatment in the preceding year, the suicide risk was 6 times increased for people receiving only psychiatric medication, 8 times for people with psychiatric outpatient contact, 28 times for people with psychiatric emergency room contacts, and 44 times for people who had been admitted to a psychiatric hospital.

Patients admitted to hospital would of course be expected to be at greatest risk of suicide because they are more ill than others (confounding by indication), but the findings were robust and most of the potential biases in the study were conservative, i.e. favoured the null hypothesis of there being no "dose-response" relationship.

An accompanying editorial noted that some people who commit suicide during or after an admission to hospital do so because of conditions inherent in the hospitalisation.[3] The authors noted that there is little doubt that suicide is related to both stigma and trauma and that it is entirely plausible that the stigma and trauma inherent in psychiatric treatment – particularly if involuntary – might cause people to kill themselves.

Patients diagnosed with schizophrenia might be told that it is a lifelong disease that sometimes requires lifelong treatment with neuroleptics,[4] and the forced treatment with these drugs may continue after they have been discharged from the hospital, under so-called community treatment orders, euphemistically called assisted outpatient treatment in the United States.

To motivate patients to take drugs they don't like because of their adverse effects, or are afraid of, psychiatrists have invented the lie that the patients' disorder is caused by a chemical imbalance in their brain, and that a drug will fix it. Many patients are still being told this,[5,6] even though the myth never had any scientific basis and has been solidly rejected.[7] This lie is very harmful because it keeps many patients on the drugs for decades[8,9] and takes aways their hope and chance of ever becoming healthy again.

There are no drugs that decrease the risk of suicide. Guidelines recommend that patients at risk of suicide be treated with antidepressants, but they double the risk of suicide, both in children and adults.[10,11,12,13,14] Curiously, those who consider themselves suicide experts also recommend depression drugs.[15] Anti-epileptics, which psychiatrists call mood stabilisers although they do not stabilise mood but sedate people, also double the risk of suicide,[16] and they are also often used for patients with severe psychiatric disorders.

The claim that incarceration is necessary and justified if psychiatric patients present a substantial danger to others, is also invalid. In Italy and Iceland, this cannot lead to forced admission to a psychiatric department, as it is considered a matter for the police, like for everybody else.

Psychiatric drugs cannot protect against violence unless the patients are drugged into a zombie-like state. Several classes of psychiatric drugs increase the risk of violence.[10,17]

Psychiatrists do not cure or substantially help patients but make matters worse

In 2016, Norwegian former Supreme Court Judge Ketil Lund and I explained in a law journal why forced medication with neuroleptics cannot be justified because the effect is poor while the drugs have considerable harms.[18] And in 2019, the Ombudsman concluded in a specific case that it violated the Psychiatry Act to use forced treatment with a neuroleptic.[19] Among other things, the Ombudsman mentioned our argument that it is misleading to assert that neuroleptics can prevent relapses in a quarter of the patients, because what is called recurrence when the patients no longer receive the drug is very often withdrawal symptoms.[4,6]

The effects of neuroleptics and of antidepressants are so poor that they are less than the least clinically relevant effect.[4,6] Electroshocks are also used as forced treatment but the effect is doubtful and temporary, which is why many shocks are usually applied, and the harms are considerable and sometimes deadly.[4,6,20] It is therefore impossible to justify forced treatment with neuroleptics, antidepressants and electroshock. These treatments do not lead to substantial improvements in the condition.

In fact, drug treatment often makes matters worse. They make it more difficult for people to function, and in all countries where this relationship has been examined, the more psychiatric drugs are being used, the more people end up on disability pension for psychiatric reasons. The time trends in the individual countries are striking.[21,22]

Torture

An exception in the law about crimes against humanity is torture, if the suffering arises from a lawful sanction, but this

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exception does not apply to psychiatric incarceration and forced treatment because they are not sanctions.

The United Nations has declared that arbitrary or unlawful deprivation of liberty based on the existence of a disability and forced administration of psychiatric drugs may constitute a form of torture.[23]

Patients often perceive forced admission as imprisonment and forced treatment as torture, and in Europe, the oversight of forced treatment comes under the convention prohibiting torture. Article 3 in the European Convention on Human Rights states: “Prohibition of torture. No one shall be subjected to torture or to inhuman or degrading treatment or punishment.”[24]

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)[25] inspects psychiatric treatment facilities with a view to strengthening, if necessary, the protection of people deprived of their liberty from torture and from inhuman or degrading treatment or punishment.

In its 2013 report,[26] the Committee noted that that the admission of a person on an involuntary basis should not be construed as authorising treatment without his or her consent. The Committee also noted that deliberate ill-treatment of patients in psychiatric establishments occurs. Psychiatrists have, for example, administered electroshocks to patients they disliked the most and have regularly prescribed shocks for those who were fighting, restless, noisy, quarrelsome, stubborn and obstinate.[27]

The restraint of agitated or violent patients was an area of particular concern to the Committee given the potential for abuse and ill-treatment. Patients have repeatedly said they felt the whole ordeal to be humiliating, a feeling at times exacerbated by the manner in which the restraint was applied. The Committee often found that patients were restrained, usually with mechanical restraints, as a sanction for perceived misbehaviour or as a means to bring about a change of behaviour. Moreover, in many psychiatric establishments, the application of restraints was a means of convenience for the staff, but the usual justification, lack of staff, is unsound. The means of restraint require more – not fewer – medical staff, as each case necessitates a member of staff to provide direct, personal and continuous supervision, which video surveillance cannot replace. This requirement is often ignored.

Based on positive experiences from some countries, the Committee raised the question whether eradication of mechanical restraint might be a realistic goal. Indeed, it is. In Iceland, seclusion and restraint were abolished in 1932 and never used again, and both measures are forbidden in some countries.[28] And studies have shown that, with adequate leadership and training of staff in de-escalation techniques, it is possible to practice psychiatry without using force.[29,30] It has also been shown that use of coercive measures is based much more on culture, traditions, and policies than on medical or safety requirements.[28,31]

The Committee noted that psychiatric patients should be treated with respect and dignity, in a safe, humane manner that respects their choices and self-determination, where free and informed consent to treatment is based on full, accurate and comprehensible information about the patient’s condition and the treatment proposed.

The Committee all too often found that fundamental components of effective psychosocial rehabilitative treatment are underdeveloped or even totally lacking, and that the treatment provided to patients consisted essentially of pharmacotherapy.

The United Nations forbids forced treatment and involuntary detention

The fundamental human right to equal recognition before the law applies to everyone, also to people with mental disorders. This is clear from the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the United Nations Convention on the Rights of Persons with Disabilities, which has been ratified by virtually all countries.[32]

In 2014, a UN report specified that member states must immediately begin taking steps towards the realisation of the rights by developing laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person’s autonomy, will and preferences.[32] The report stated that mental health laws that permit involuntary detention and forced treatment must be abolished.

It furthermore noted that forced treatment is ineffective and that people exposed to it have experienced deep pain and trauma as a result.

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A person's mode of communication must not be a barrier to obtaining support in decision-making, even where this communication is non-conventional, or understood by very few people.[32] Where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the "best interpretation of will and preferences" must replace the "best interests" determinations.

Children's views must be given due weight in accordance with their age and maturity, so that the will and preferences of children with disabilities are respected on an equal basis with other children.

The current practice of psychiatry

There is an extreme power imbalance in closed psychiatric wards and there is a high propensity for forced treatment to be used to benefit staff rather than patients to make their work less stressful. There is nothing psychiatric patients fear more than forced treatment. They have been the victims of punitive measures for centuries without their consent, and the mere threat of such measures has often terrified patients to such an extent that they become docile in order to avoid them.

Many patients have reported how the threat of mechanical restraints has been used to discipline them into taking drugs, which they didn't want because of their terrible harms. If the patients live in a treatment home after discharge and refuse to take the pills, they might be kicked out of the facility and involuntarily readmitted to hospital, lose their social benefits, and even be denied access to a mental healthcare centre.[27]

As I have explained above, State laws about coercion are highly problematic. It can be argued that these laws are in themselves such a serious violation of basic human rights, with dire consequences in terms of loss of life and permanent suffering, that they constitute a crime against humanity.

In addition, the laws we have are not even respected. They are routinely violated all over the world but no one cares - even Supreme Court and Ombudsman decisions are being ignored, e.g. in Alaska and Norway.[10,33,34]

These transgressions have not left much imprint on the scientific literature. Only two studies have examined in cohorts of patients what happens when they appeal forced treatment orders while being detained in a psychiatric institution.

I conducted both studies. I got access to 30 consecutive cases from the Psychiatric Appeals Board in Denmark and found that the law had been violated in every single case.[35,36] All the patients were forced to take neuroleptics, even though less dangerous alternatives could have been used, e.g. benzodiazepines, which are better,[37] and which all patients have said they would prefer when I asked them during my lectures. But the psychiatrists had no respect for the patients' experiences and views. In all 21 cases, where there was information about the effect of previous drugs, the psychiatrists claimed a good effect whereas none of the patients shared this view.

The harms of prior medication played no role either in the psychiatrist's decision making, not even when they were serious. We suspected or found akathisia or tardive dyskinesia in seven patients, and five expressed fears of dying because of the forced treatment. We doubted the psychiatrists' diagnoses of delusions in nine cases, and there is an element of catch-22 when a psychiatrist and a patient disagree. According to the psychiatrist, it shows the patient has a lack of insight into the disease, which is a symptom of their mental illness.

On his web page, lawyer Jim Gottstein explains that psychiatrists, with the full understanding and tacit permission of the trial judges, regularly lie in court to obtain involuntary commitment and forced medication orders.[38] When I visited Jim in Anchorage in 2016 to give a talk about why forced treatment must be abolished,[39] I saw examples of some of these lies and was an expert witness in the Alaska Superior Court in one of these cases.

By using scientific data, Jim had previously convinced the Alaska Supreme Court that the government cannot drug someone against their will without first proving by clear and convincing evidence that it is in their best interests and there is no less intrusive alternative available.[10,40] .

I wanted to do a study of 30 consecutive petitions from Anchorage and Jim acted as my attorney in obtaining them. He was met with so many obstacles that it took over four years of litigation, including two trips to the Alaska Supreme Court, before I was granted access to redacted records. I published our findings with US psychiatrist Gail Tasch who scrutinised the records.[34] Involuntary medication orders were requested for all the patients, and we found that the legal procedures can best be characterised as a sham where the patients are defenceless.

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In violation of previous Alaska Supreme Court rulings, the patients' experiences, fears, and wishes were ignored in 26 cases even when the patients were afraid that the neuroleptics might kill them or when they had experienced serious harms such as tardive dyskinesia.

Several of the psychiatrists obtained court orders for administering drugs and dosages that were dangerous. The ethical and legal imperative of offering a less intrusive treatment was ignored, e.g. benzodiazepines were not offered. And the psychiatrists claimed, contrary to the evidence,[4,6] that psychotherapy doesn't work. They never provided psychotherapy or family therapy.

If we want to find out how lethal neuroleptics are, we cannot use trials in patients with schizophrenia because virtually all patients were already in treatment before they got randomised, and those switched to placebo were exposed to withdrawal effects, which increase mortality,[41] mainly because of suicide, as withdrawal akathisia is an unbearable symptom. If we focus on elderly, demented patients instead, assuming that few of them were in treatment before they were randomised, we find that neuroleptics kill two patients for every 100 treated in just ten weeks.[42]

Neuroleptics are some of the most toxic drugs ever invented and shouldn't be used for anyone. But guidelines all over the world tell psychiatrists to use these drugs.

We must work together to abolish mental health laws that permit involuntary detention and forced treatment. Lawsuits, documentary films and interviews can be valuable means to push for the much-needed changes. I am currently an expert witness in a pro bono lawsuit against the Norwegian state, which we intend to appeal to the European Court of Human Rights in Strasbourg if we lose.[43]

Jim Gottstein, author of the terrific book, *The Zyprexa papers*, and I appear in the documentary film, *Diagnosing Psychiatry*,[44] and he also appears in an interview I made with him in 2023 on *Broken Medical Science*, the film and interview channel I created with documentary filmmaker and historian Janus Bang.[45] There are other interviews with experts on our channel, e.g. Professor of Clinical Psychology John Read explains why electroshock will likely become abandoned.[46] John is an expert witness in ongoing lawsuits in the USA related to this.[47] Another, very important avenue to push for changes in psychiatry is the *Mad in America* website created by science journalist Robert Whitaker,[48] and it might also help to produce white papers.[49]

Disclosures, Funding & Conflicts of Interest

None in relation to this paper. I am an expert witness for the same law firm as John Read is, but not in relation to psychiatry.

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Submitted to JAPH on 12/26/2024

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